

# 2010 KEHP Dependent Eligibility Verification Program

## APPEAL REQUEST FORM

### Group 2



#### Appeals Process Guidelines

You may appeal the termination of your dependent(s) from the Kentucky Employees' Health Plan (KEHP). You must complete this form and include all supporting documentation (as defined in previous Dependent Eligibility Verification Program communications) to verify that your dependent is eligible to be covered under KEHP.

This completed form and all documentation must be received by **KEHP on or before August 30, 2010** to be considered for KEHP Plan Year 2010. You will be notified in writing of the outcome of your appeal. Based on the appeal type, you may be required to submit additional documentation which verifies that your dependent meets KEHP's eligibility guidelines.

***Completion of this appeal form does not guarantee that your dependent(s) will be covered under KEHP.***

#### To Be Completed by Employee (KEHP Planholder)

**Employee Name** (please clearly print first name, middle initial and last name)

\_\_\_\_\_

**Employee SSN** \_\_\_\_\_ **Employee Company/Agency Number** \_\_\_\_\_

**Employee Address & Daytime Phone Number** \_\_\_\_\_

**Dependent(s) Information** (Documentation verifying eligibility must be included for each dependent listed)

**Name / Relationship / DOB** \_\_\_\_\_

**Name / Relationship / DOB** \_\_\_\_\_

**Name / Relationship / DOB** \_\_\_\_\_

Please use the area below to explain why you did not comply with this program. (Use an additional page if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Employee Signature and Date**

Return this completed form and your documentation to:  
**Kentucky Employees' Health Plan**  
501 High Street, Frankfort KY 40601, Attn: Appeals Committee  
or fax to (502) 564-1085